

INSTRUCTIONS

bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10118

10133 CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Calvert</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Calvert</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>North Beach</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>North Beach</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>2nd Street</i>		STREET ADDRESS <i>2nd Street</i>	
3. NAME OF DECEASED (First) <i>ALYCE</i> (Middle) <i>M.</i> (Last) <i>CATLETT</i> (Type or Print)		4. DATE (Month) (Day) (Year) <i>October 19 1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>11 May 1915</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if <i>House wife</i>)		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>South Dakota</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Andrew Nelson</i>		14. MOTHER'S MAIDEN NAME <i>Cecilia Jensen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)	
17. INFORMANT & ADDRESS <i>Paul H. Catlett (Husband) Same as # 2</i>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.1 IMMEDIATE CAUSE (A) Coronary occlusion</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>2/1/10 1954</i> to <i>10/1 1956</i> , that I last saw the deceased alive on <i>10/1/16 1956</i> , and that death occurred at <i>8:10 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>H. Neens</i> M.D. ADDRESS (Street, city, town, state) <i>Huntingtown Md</i> DATE SIGNED <i>19/19/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>22 Oct. 1956</i>	
24. REC'D BY REGISTRAR DATE <i>OCT 23 1956</i>		NAME OF CEMETERY OR CREMATORIUM <i>Ceder Hill Cemetery</i>	
REGISTRAR'S SIGNATURE <i>Elsie B. Catlett</i>		LOCATION (City, town, or county) <i>Suitland Pr. Geo. Md.</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Maryland</i>	

OF BROWNSBURG-INIANA TO INDIANA STATE GRANT

INDIANA TO STATE GRANT

service 50%
service

service

use ratio

use

use ratio

the people

the people

cooper 10

TRAITOR

X

ORIA

IT

IT is a JET

efficiency

shuttle

stocks

in home

cities, mean

new nation

3 00 000 (standard) 1000 H. Gafford (passenger) 000 00

BUREAU V. S

OCT 23 1956

DEPARTMENT OF STATE
WASHINGON D. C.

"such a gone satellite" is being

list

SS

COPIES FEE RECORD IT IS GOALS ET AL PRACTICALLY 1.00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
Form 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												10120	
Item 4 FilmG206 11-6-56 et 10134 Item 8. See: Birth Cert.												Reg. Dist. No. 57	
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Calvert									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dunkirk									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert & F 64				d. STREET ADDRESS									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Baby		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
5. SEX F		6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/17/56	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md								
					12. CITIZEN OF WHAT COUNTRY?								
13. FATHER'S NAME Edgar Franklin				14. MOTHER'S MAIDEN NAME Sarah Evans									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown				16. SOCIAL SECURITY NO. 17. INFORMANT Address									
18. CAUSE OF DEATH [Enter only one cause of death for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 763.5 DUE TO <i>Bremadine - phenacetin</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Born B.O.F. 2 hrs before autopsy was taken care				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
21. I certify that I attended the deceased from 10/26, 1st to 10/28/56, 19, that I last saw the deceased alive on 10/28, 19, and that death occurred at 11:30 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)									
ACTUAL SIGNATURE H.W. Ward M.D.				DATE SIGNED 10/28/56									
PHYSICIAN'S NAME (Type)													
22a. BURIAL/CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10-1-56		22c. NAME OF CEMETERY OR CREMATORIUM Plum Court		22d. LOCATION (City, town, or county) Calvert		(State) Md					
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell. On Fred. Md				ADDRESS									
				24a. REC'D BY REGISTRAR DATE 10-31-56		24b. REGISTRAR'S SIGNATURE H. W. Ward							

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
CITY OF BALTIMORE, MARYLAND

BUREAU OF INVESTIGATION

NOV 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10135

CERTIFICATE OF DEATH

Reg. Dist. No.

10121
51

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		
<i>Cabret</i> MARYLAND		Maryland County <i>Cabret</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Huntingtown	Life	Huntingtown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<i>None</i>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
<i>Nellie</i>	<i>E.</i>		<i>Lisbon</i>	
4. DATE OF DEATH	Month	Day	Year	
<i>Oct.</i>	<i>21</i>		<i>1956</i>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	
<i>F</i>	<i>W</i>		<i>April 28, 1877</i>	
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Year Hours	
<i>79 yrs.</i>	<i>5</i>	<i>23</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>	<i>Home</i>	<i>Cabret Co., Md</i>	<i>U. S. A.</i>	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
<i>Anthony Lyons</i>	<i>Sarah Lester</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
<i>No</i>	<i>20</i>	<i>Eldridge Lisbon - Huntingtown, Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	<i>Cerebral Hemorrhage</i>			
<i>331X</i>	DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	<i>Arteriosclerosis</i>		
(b)	DUE TO			
(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
	<i>19</i>			
21. I certify that I attended the deceased from <i>Oct 20</i> , 1956, to <i>Oct 21</i> , 1956, that I last saw the deceased alive on <i>Oct 20</i> , 1956, and that death occurred at <i>M.</i> from the causes and on the date stated above.	ADDRESS (Street, city or town, state)			DATE SIGNED
ACTUAL SIGNATURE <i>Page C. Jett</i>				<i>October 21, 1956</i>
PHYSICIAN'S NAME (Type) <i>PAGE C. JETT</i>				
22a. BURIAL, CREMATION, REMOVAL (specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct. 23, 1956</i>	22c. NAME OF CEMETERY OR Crematory <i>Huntingtown Methodist</i>	22d. LOCATION (City, town, or county) <i>Huntingtown - Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness & Son - Mutual, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>10/23/56</i>	24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

81 JOURNAL OF HEALTH-CAUTIION

OCT 24 1956

RECEIVED
OCT 24 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10122

1. PLACE OF DEATH a. COUNTY		10136 <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE <i>maryland</i>		b. COUNTY <i>Calvert</i>		
Prince Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		<i>County Hospital</i>		d. STREET ADDRESS		<i>Busley</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. DATE OF DEATH		Month	Day	Year
3. NAME OF DECEASED (Type or print)		First <i>THELMA</i>	Middle <i></i>	Last <i>GRAHAM</i>	10 - 20 - 1956	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
4. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) 28 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
House wife				<i>Maryland</i>		<i>U.S.A.</i>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
<i>Unknown</i>		<i>Pauline Wallace</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		
						<i>Crushing Injury of Chest</i>		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO				INTERVAL BETWEEN ONSET AND DEATH		
816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)						
DUE TO		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
10 p.m. 10-20 1956				STREET RTE 231 CHARLES Mo				
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>R. S. Fisher</i>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>10-21-56</i>		
EXAMINER'S NAME (Type) <i>R. S. Fisher</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-25-56</i>		22b. DATE THEREOF <i>10-25-56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Island Creek</i>		22d. LOCATION (City, town, or county) (State) <i>mutual Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. J. Sevill, Ph. Fred, Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>10-26-56</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Five Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHB. Page 5 may be retained by your funeral director. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with registrar prior to removal.

ANALYSTS AT THE NATIONAL SECURITY AGENCY-ADAMSON ARE
ARMED WITH THE EXAMINER'S CERTIFICATE OF DEATH.

10-10-01 100000 100000

1960-1961 - 1962-1963

BUREAU Y.

OCT 30 1956

RECEIVED
1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 51

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by your file.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Chestertown</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>	c. LENGTH OF STAY IN 1b <i>1 week</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>	d. STREET ADDRESS <i>100 Main Street</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Chase</i>	First <i>Mary</i>	Middle <i>Chase</i>	Last <i>Wicks</i>
4. DATE OF DEATH Month <i>10</i>	Day <i>17</i>	Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 4 '91</i>
9. AGE (In years at birthday) <i>65 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>None</i>
13. FATHER'S NAME <i>Joe Chase</i>	14. MOTHER'S MAIDEN NAME <i>Elyne Marshall</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Joe Wicks Huntingtown</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>	
DUE TO <i>331X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>None</i>	
Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause lost. <i>None</i>		DUE TO <i>(b)</i>	
DUE TO <i>None</i>		DUE TO <i>(c)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Had had high blood pressure</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Found dead in bed</i>		
20c. TIME OF INJURY Month, Day, Year Hour <i>11/10/11 12 p.m.</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Huntingtown Chestertown Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> <i>H. W. Ward</i>			
ACTUAL SIGNATURE <i>H. W. Ward</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>10/11/58</i>
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-14-58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Bethel</i>	22d. LOCATION (City, town, or county) (State) <i>Huntingtown Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell Jr. Fred. Md.</i>	ADDRESS <i>None</i>	24a. REC'D BY REGISTRAR DATE <i>10-11-58</i>	24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>

STATE EXAMINER'S CERTIFICATE OF PRACTICE

BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10138

CERTIFICATE OF DEATH

10124

Reg. Dist. No. 51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b Calvert County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Wilbert		First Wilbert	Middle Oscar	Last Jones	4. DATE OF DEATH October	Month October	Day II	Year 1956		
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 11, 1956	9. AGE (In years lost birthday) yrs. 5	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Elvin Jones		14. MOTHER'S MAIDEN NAME Evangeline Smith								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Evangeline Smith Chesapeake Beach, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature (6th month)						INTERVAL BETWEEN ONSET AND DEATH				
761.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Breach presentation (foot) cervix not								
		DUE TO (c) fully dilated (6cm)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Supplib (?) in Mother						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) St. Leonards, Md.	(County) Calvert Co.	(State) Md.				
21. I certify that I attended the deceased from To/II/56 , 19, to To/II , 1956, that I last saw the deceased alive on To/II , 1956, and that death occurred at 6:35 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) St. Leonards, Md.		DATE SIGNED To/12/56				
ACTUAL SIGNATURE R. de Villarreal										
PHYSICIAN'S NAME (Type) Dr. Roberto de Villarreal										
22a. BURIAL/CREMATION, REMOVAL (Specify) 10-13-56		22b. DATE THEREOF 10-13-56	22c. NAME OF CEMETERY OR CREMATORIUM St. Edmunds	22d. LOCATION (City, town, or county) Calvert Co.	(State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Calvin Jones - Chesapeake Beach, Md.		ADDRESS 2064193xv1		24a. REC'D BY REGISTRAR H. W. Ward	24b. REGISTRAR'S SIGNATURE H. W. Ward					

CERTIFICATE OF DEATH

MATERIALS

DEPARTMENT OF HIGHWAY

THE STATE OF CALIFORNIA

RECEIVED

BUREAU V.
RECEIVED
OCT 13 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10125

10-39

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 9 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olivet			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First George	Middle Washington	Last Kent	4. DATE OF DEATH TO 2	Month 19	Day 2	Year 56
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 68	9. AGE (In years lost birthday) yrs. 68	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Peter Kent		14. MOTHER'S MAIDEN NAME Korsha Woodkin		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT David Watkins (Son in Law)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) - Acute nephritis - DUE TO		Chenia		INTERVAL BETWEEN ONSET AND DEATH			
(c) Generalized arterio-sclerosis DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Olivet	(County)	(State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE Physician's NAME (Type)				ADDRESS (Street, city or town, state) 5 St. Leonard, Md.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-4-5	22b. DATE THEREOF 10-4-5	22c. NAME OF CEMETERY OR CREMATORIAL Eastern	22d. LOCATION (City, town, or county) Olivet			(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Seawell	ADDRESS Prince Fred.	24a. REC'D BY REGISTRAR DATE 10-2-56	24b. REGISTRAR'S SIGNATURE H. W. Ward				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 To be returned by the hospital or attending physician.
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be attached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU N.Y.
RECEIVED
OCT 3 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10126

Reg. Dist. No. 52

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please enter "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mr Beach</i>		c. LENGTH OF STAY IN 1b <i>10 days</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <i>714-3rd street</i>				
3. NAME OF DECEASED (Type or print) <i>McNamee James John</i>		4. DATE OF DEATH <i>Oct 22 1956</i>	Month <i>10</i> Day <i>22</i> Year <i>1956</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 7 1895</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fine Art Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTH PLACE (State or foreign country) <i>Wash DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>James McNamee</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Kelly</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>				
17. INFORMANT <i>Mrs M. McNamee, M.D. Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i></i> (a), stating the underlying cause (c) <i></i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Dropped dead while going out</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i></i>				
20c. TIME OF INJURY Hour <i>a.m.</i>	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Arlington</i>	(County) <i>Va.</i>	(State) <i>Va.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>H. Ward</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <i>Own hand 10/22/56</i>		
EXAMINER'S NAME (Type) <i></i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/25/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Arlington Nat'l Cemetery</i>	22d. LOCATION (City, town, or county) <i>Arlington</i>	(State) <i>Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Valley's Funeral Home, Inc.</i>	ADDRESS <i>1st & Rainier</i>		24a. REC'D BY REGISTRAR <i>REC'D 25 OCT 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Ebie M. Colle</i>	DATE <i>25 OCT 1956</i>	

RECEIVED
OCT 25 1956
BUREAU N.Y.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10127

CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Priests Frederick</i>		c. LENGTH OF STAY IN 1b <i>19 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Benedict</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Harry</i>	Middle <i>G</i>	Last <i>Messick, Jr.</i>	4. DATE OF DEATH <i>October 27 1956</i>	Month <i>October</i>	Day <i>27</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>8/13/1877</i>	9. AGE (In years last birthday) <i>79</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tavern Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin Messick</i>		14. MOTHER'S M AIDEN NAME <i>Stafford</i>		Address <i>Benedict, Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>no</i>	17. INFORMANT <i>Harry messick, Jr.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Congestive heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>b) Arteriosclerosis</i>		DUE TO <i>c)</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral vascular accident (hemorrhage)</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Oct 27, 1956</i>					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Hughesville, Md.</i>	(County) <i>Hughesville</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Oct 27, 1956</i> , to <i>Oct 28, 1956</i> , that I last saw the deceased alive on <i>Oct 27, 1956</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Roger L. Jett</i>		M.D.		ADDRESS (Street, city or town, state) <i>Hughesville, Md.</i>		DATE SIGNED <i>Nov 1 1956</i>	
PHYSICIAN'S NAME (Type) <i>Roger L. Jett</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Old Fields Cem.</i>		22d. LOCATION (City, town, or county) <i>Hughesville, Md.</i>		(State) <i>Md.</i>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-30-56</i>		22d. LOCATION (City, town, or county) <i>Hughesville, Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home Waldorf, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>NOV 1 1956</i>		24b. REGISTRAR'S SIGNATURE <i>H. Hard</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 To be returned by the hospital or attending physician.
 GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.I.C.

O.V. I 1956

REGITIVE

22 23 24 25 26 27 28 29 29 30 31 32 33 34 35 36 37 38 39 39 40 41 42 43 44 45 46 47 48 49 49 50 51 52 53 54 55 56 57 58 59 59 60 61 62 63 64 65 66 67 68 69 69 70 71 72 73 74 75 76 77 78 79 79 80 81 82 83 84 85 86 87 88 89 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 49 50 51 52 53 54 55 56 57 58 59 59 60 61 62 63 64 65 66 67 68 69 69 70 71 72 73 74 75 76 77 78 79 79 80 81 82 83 84 85 86 87 88 89 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 49 50 51 52 53 54 55 56 57 58 59 59 60 61 62 63 64 65 66 67 68 69 69 70 71 72 73 74 75 76 77 78 79 79 80 81 82 83 84 85 86 87 88 89 89 90 91 92 93 94 95 96 97 98 99 100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10128

10142

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY Cabret MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cabret		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick	c. LENGTH OF STAY IN 1b 7 wks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick	x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cabret County Hospital	d. STREET ADDRESS _____	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ida	First	Middle E. Rawlings	Last Oct. Day Year 25, 1956	
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1877 9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Cabret Co., Md	
13. FATHER'S NAME Frances Scivener		14. MOTHER'S MAIDEN NAME Elizabeth Wood	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Mae Rawlings - P. Frederick, Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hypertension C.V.D. (c) DUE TO Jaundice (Not determined).				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 25, 1956, to Oct. 25, 1956, and that death occurred at M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 57 Leonard St. 10/25/56		
ACTUAL SIGNATURE R. de VILLARREAL		M.D. ST. LEONARD, MD.		
PHYSICIAN'S NAME (Type) R. de VILLARREAL				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 27, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Asbury Cemetery	22d. LOCATION (City, town, or county) Berwyn - Cabret Co - Md (State)
23. FUNERAL DIRECTOR'S SIGNATURE A. A. Harkness & Son - Mutual, Md		ADDRESS	24a. REC'D BY REGISTRAR DATE 10-26-56	24b. REGISTRAR'S SIGNATURE H. H. Hard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. It should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSOURI STATE DEPARTMENT OF HEALTH - ST. LOUIS

CERTIFICATE OF DEATH

BUREAU V.

OCT 30 1956

RECEIVED

10129

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 950

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute your certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your signature.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Solomons		c. LENGTH OF STAY IN 1b 11 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg R.F.D. 2	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William L. Schiver		4. DATE OF DEATH October 1 1956	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1927
9. AGE (In years last birthday) 29 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Tidewater Fisheries	
11. BIRTHPLACE (State or foreign country) Frostburg, Md		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank E. Schiver		14. MOTHER'S MAIDEN NAME Margaret Blank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 11 212-21-0577	17. INFORMANT (Schiver) Hazel Schiver
		Address Solomons, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning			
850 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) apparently fell from boat and drowned	
20c. TIME OF INJURY Month, Day, Year Between 8 a.m. & 7-8 Oct 1956		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bay
		20f. (City or town) Solomons	(County) Calvert
		(State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>William Lovitt</i>		DATE SIGNED October 4, 1956	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-7-56	
22c. NAME OF CEMETERY OR CREMATORIAL HOME Frostburg Memorial Park Frostburg		22d. LOCATION (City, town, or county) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Benedict H. Montesano		24a. REC'D BY REGISTRAR 10-7-56	
		24b. REGISTRAR'S SIGNATURE H. Diane Harvey	

EXAMINER'S CERTIFICATE OF DEATH

SEARCHED	INDEXED
SERIALIZED	FILED
FBI - NEW YORK	
OCT 9 1956	

FBI - NEW YORK

OCT 9 1956

RECEIVED

10141 CERTIFICATE OF DEATH

Reg. Dist. No. 51

INSTRUCTIONS
The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN end give nearest town)	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Maryland Prince Frederick (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Pr. Fred. md.</i>	STREET ADDRESS		
3. NAME OF DECEASED (Type or Print) <i>Ernestine Thomas</i>	(First) (Middle) (Last)	4. DATE (Month) (Day) (Year) OF DEATH 10 18 19 56	
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Oct 10-1894</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>washington D.C. U.S.A.</i>
13. FATHER'S NAME <i>Calvin Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Mary O. Free land.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>[Redacted]</i>	
17. INFORMANT & ADDRESS <i>Calvin Thomas Pr. Fred. md.</i>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>Hypertension C.V. Disease</i>	
443 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>6 years</i>	
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct 16 19 56</i> , to <i>Oct 18 19 56</i> , that I last saw the deceased alive on <i>Oct 18 19 56</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Jane S. D.</i>		ADDRESS (Street, city, town, state) <i>Bunee Indeck</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <i>10-21-56</i>	
NAME OF CEMETERY OR CREMATORIAL <i>Oliver</i>		LOCATION (City, town, or county) <i>Pr. Fred. md.</i>	
24. REC'D BY REGISTRAR DATE 10-19-56		REGISTRAR'S SIGNATURE H. W. Ward	
25. FUNERAL DIRECTOR'S SIGNATURE P. E. Sawell, Pr. Fred. md.		ADDRESS	

STATE OF MARYLAND - DEPARTMENT OF HEALTH

DEPARTMENT OF PUBLIC WELFARE
MATERIALS CERTIFICATE

APPROVED FOR USE IN MARYLAND

EXPIRES NOV.

1956

Applicant's Name
John Doe

BUREAU V. S.

OCT - 22 1956

RECEIVED
CITY OF BALTIMORE
OCT 22 1956

OCT 22 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10131

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>Calvert County Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barstow</i>		d. STREET ADDRESS <i>—</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Murphy</i>	Middle <i>J.</i>	Last <i>TUCKER</i>	4. DATE OF DEATH <i>October 26 1956</i>	Month	Day	Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/20/03</i>	9. AGE (In years lost birthday) <i>53 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dry Cleaning</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Augustus Tucker</i>		14. MOTHER'S MAIDEN NAME <i>Eunathie McVoy</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-03-970</i>		17. INFORMANT <i>Mrs. Edith Tucker - wife - Barstow, Md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443x</i>		DUE TO <i>Cardiac Failure (acute)</i>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Hypertension & Disease</i>		(b) DUE TO <i>—</i>		(c) <i>—</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		Month <i>Oct.</i>	Day <i>26</i>	Year <i>1956</i>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Barstow</i>	(County) <i>—</i>	(State) <i>—</i>
21. I certify that I attended the deceased from <i>Jan. 21, 1956</i> , to <i>Oct. 26, 1956</i> , that I last saw the deceased alive on <i>Aug. 26, 1956</i> , and that death occurred at <i>5:30 P.M.</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>—</i>			DATE SIGNED <i>—</i>
ACTUAL SIGNATURE <i>George E. Jett</i>		PHYSICIAN'S NAME (Type) <i>PAGE C. JETT</i>		PRINCE FREDERICK, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 28, 1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Ashley Cemetery</i>		22d. LOCATION (City, town, or county) <i>Barstow, Md.</i>		(State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. O. Hawkins & Son - Funeral, Md.</i>		ADDRESS <i>—</i>		24a. REC'D BY REGISTRAR <i>10-28-56</i>		24b. REGISTRAR'S SIGNATURE <i>H. H. Ward</i>			

81-350048-172058 DEPARTMENT OF STATE 6/17/74

BUREAU V. S.

OCT 30 1956

REGELY ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be attached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be attached for use as the burial, cremation, or removal, and in any event within 72 hours after death. The registrar price

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 FilmG207 11-21-56 et

10132

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH o. COUNTY <i>Calvert</i>		10145 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i>		b. COUNTY <i>Annapolis</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN lb <i>5</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendship</i>		d. STREET ADDRESS <i>02 X 2</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital Center</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Alice Elma Wood</i>		First	Middle	Last	4. DATE OF DEATH <i>October 24 1956</i>	Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>W.H.C.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 27 1881</i>	9. AGE (In years last birthday) <i>75</i>	10. IF UNDER 1 YEAR Months <i>7</i>	11. IF UNDER 24 HRS. Days <i>5</i>	12. Hours <i>17</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>James Troxer</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Stevens</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Samuel Trox - Friendship</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Coronary Occlusion</i>				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b)		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Huntingtown, Md.</i>		20f. (City or town) (County) <i>Huntingtown, Md.</i>		(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Feb.</i> , 1956, to <i>October 26, 1956</i> , that I last saw the deceased alive on <i>Oct. 20, 1956</i> , and that death occurred at <i>4:00 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Huntingtown, Md.</i>		DATE SIGNED <i>10/24/56</i>		
ACTUAL SIGNATURE <i>G. Weems</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>George J. Weems</i>		Huntingtown, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/27/56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Friendship Cemetery</i>		22d. LOCATION (City, town, or county) <i>Friendship, Maryland</i>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. H. Hutchins</i>		ADDRESS <i>Avon Park</i>		24a. REC'D BY REGISTRAR <i>10/27/56</i>		24b. REGISTRAR'S SIGNATURE <i>Grace L. Hutchins</i>		

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH
MURKIN, ROBERT L.					
1000 N. 12th Street, Milwaukee, Wisconsin					
BORN: JUNE 10, 1914					
DIED: NOVEMBER 7, 1956					
WEIGHT: 160 POUNDS					
HEIGHT: 5 FEET 7 INCHES					
HAIR: BLACK					
EYES: BLUE					
CLOTHING: DARK SUIT, WHITE SHIRT, DARK TIE					
APPEARED TO BE IN GOOD HEALTH UNTIL NOVEMBER 6, 1956, WHEN HE WAS FOUND DEAD IN HIS BEDROOM.					
DEATH CERTIFIED BY:					
DR. RICHARD H. KELLY					
MILWAUKEE, WISCONSIN					
NOVEMBER 7, 1956					

BUREAU V. 5
RECEIVED
NOV 7 1956